CPCA
California Primary Care Association

Health Care Access for All

July 9, 2012

RE: DRAFT Initial Low Income Health Program (LIHP) Transition Plan

On behalf of the California Primary Care Association's (CPCA) membership of community health centers and community clinics across California, I would like to submit the following comments on the DRAFT Initial LIHP Transition Plan ("the Plan"). Generally we are supportive of the Plan and appreciate the thoughtfulness with which it was crafted. There are a few areas, however, where we believe additional detail and layered partnerships would serve to strengthen the seamlessness of the transition of clients from LIHP to Medi-Cal.

STC 23.a.i. and 23.a.ii.

While there is no section of the Plan focused on overarching policy, ***CPCA recommends that the state form a Policy Taskforce***. It is clear from the evaluation of the SPD transition that many challenges arose from unclear policies and policies that changed throughout the transition. One strategy to avoid this pitfall is to create a Policy Taskforce comprised of key state, LIHP, provider and beneficiary representatives. While the Plan itself will provide the structure for the policies, additional work will be necessary to define the nuances set forth in the Plan that will dictate the transition. A Policy Taskforce with stakeholder input will ensure buy-in up front and consistency throughout the transition process.

Communication of Eligibility for Medicaid and Exchange & Communication of Medi-Cal Managed Care Plan Assignment

Due to the fluidity of eligibility and managed care plan assignment, we recommend combining the communication strategy for the two subsections into one strategy. As such, the following comments are meant to address both sections of the Plan.

In regards to the draft Plan itself, DHCS proposes to partner with local LIHPs and the Exchange to communicate information about the transition. However, we believe it necessary to also include community clinics and health centers and public hospitals, as well as other major provider groups within each LIHP. While it may be implied that each LIHP will reach out to these provider groups without calling direct attention to the importance of working with these groups it's possible that they will not be integrated into the transition. As we saw during the seniors and persons with disabilities (SPD) transition, not including the beneficiary's health care providers led to much confusion for the beneficiaries and the providers who were absorbing responsibility for these new populations. It's natural for beneficiaries to turn to their health care providers for information regarding their health care coverage status. ***In order to ensure that clear, comprehensive, and correct information is disseminated to the transitioning population, it's critical to include health care providers as key players in the development of the outreach and education plan.***

In order to meaningfully collaborate with a wider range of critical partners, we recommend the creation of a Communications Taskforce. The Taskforce should be comprised not only of state representatives from DHCS to DMHC, but also a few LIHPs, providers including community clinics and health centers and public hospitals, as well as beneficiary representatives, including consumer advocate groups, promotoras, health outreach workers, or the Exchange's Navigators. The provider and beneficiary representatives will understand the on-the-ground reality of the service delivery model and the questions and needs that beneficiaries will have during the transition. The Communications Taskforce could handle the communication strategy ranging from eligibility to assignment. They also must craft all the communication that is directed towards the LIHPS, providers and beneficiaries. This will ensure consistency in messaging.

In addition, CPCA recommends that ***all written communication created by the Taskforce and directed at beneficiaries be written for a low-literacy audience and available in all Medi-Cal threshold languages.*** Further, we recommend that the written communication also include a tagline in at least 16 different languages with a telephone number that the beneficiary can call for assistance, as well as informing individuals that oral interpretation at all points during the transition, including assistance with health plan choice, will be provided in any language at no cost to the individual as required by state and federal law.

The material and messaging produced by the Communications Taskforce should populate a section of the LIHP webpage dedicated to transition issues. The webpage needs to be up-to-date and should be organized by interested party, be it health plan, provider or beneficiary.

With the input of the Communications Taskforce, ***DHCS ought to create short and concise webinars.*** The webinars should focus on key elements of the transition and should have ample time for questions and answers at the end. We recommend no longer than 20 to 30 minutes and that there be a series of webinars that are downloadable for providers, advocates and county representatives to watch. The webinars should be targeted to the aforementioned groups and not beneficiaries because beneficiaries are most likely to receive their information from written communication or direct one-on-one communication from their providers or beneficiary advocates.

We highly encourage the state to facilitate a process by which the LIHPs, health plans, and providers create beneficiary communication strategies. It is not necessary for the state to invest much time in communicating with the beneficiaries directly as it was shown to be ineffective, at least with the SPD transition. The most effective approach is for providers or beneficiary advocates to directly communicate with the beneficiaries; however such communication would be strengthened if they had the support of their county partners, health plans, and patient advocates. Each LIHP will have its own strategy and as such the state only needs to create a venue to facilitate that planning rather than dictate how the strategy is implemented in each county. While direct assistance is not mentioned in the Plan, ***we recommend that a direct assistance strategy be incorporated into each LIHPs outreach strategy.*** The providers and the beneficiary advocates are the best vehicle to provide this support.

Finally, we suggest designating one office at DHCS to field questions on the LIHP. The evaluation of the SPD transition revealed that this was not done or at least not clearly done with that transition, and had there been one key location to direct questions, some of the transition confusion could have been eased. It may also be necessary for each county to designate a staff or office to LIHP transition questions and these individuals or offices would then need to be in close communication and coordinate with the state designated office. Ideally, the state service center would have information on the transition that was developed by the Exchange. That way, a single message and single line of communication could be used for beneficiaries, Navigators, and providers who have questions about the transition and the Medi-Cal expansion.

Medi-Cal Managed Care Plan Assignment

Plan Assignment

We are supportive of the state's proposal that the plan assignment should focus on retaining a LIHP enrollee's medical home whenever possible. Further we are supportive of the "opt-out" approach proposed, with a few extra but important details. ***We recommend first assigning beneficiaries based on the primary care provider they had the most visits with, and if that doesn't work, to assign beneficiaries to the last primary care provider that beneficiary saw***. As part of the communication, beneficiaries should clearly understand that they have the right to opt-out of who they are being assigned to and that they can instead choose another provider. Beneficiaries should be provided a list of other providers they could choose if they so opted. This is particularly important for the few of counties where the provider networks are very small and exclusive and in those counties where the beneficiary had to switch providers when they began the LIHP because that provider was prohibited from contracting in the LIHP. Beneficiaries should have a choice to choose prior providers once the transition to Medi-Cal is complete.

Rate Setting

CPCA has concerns regarding the data to be used to determine rates, which is only the demographic characteristics and utilization patterns from the LIHPs. Currently, the quality of LIHP data is very uneven, and it is our understanding from member clinics and health centers that the utilization rates are under-reported. Further "out-of-network" hospitals do not verify LIHP enrollees consistently and often do not bill because of the low financial incentive. Lastly, the LIHP and the Medi-Cal scope of benefits is not the same and thus not a fair measure for determining future Medi-Cal rates. ***We recommend that the state supplement the rate setting analysis with Medi-Cal data for comparable populations and other actuarial data sets.***

Information Systems and County Collection of Data Elements

The SPD transition should be closely looked at when developing the information systems necessary for the transition. In Los Angeles, the various systems were not ready for the transition and it led to many problems. ***One way for this obstacle to be avoided in the LIHP transition is for DHCS to form a Systems Taskforce that reviews system capabilities in all the LIHPs and then prioritizes what is a) critical, b) important but not immediately necessary, and c) not necessary by January 1, 2014.*** The Taskforce can then assist the LIHPs and state in prioritizing which system changes must be put in place first and those which can subsequently follow.

In addition, ***CPCA believes that it would streamline the process for the beneficiaries transitioning from LIHP into Medi-Cal if the transition was integrated as much as possible into the single streamlined application process being developed by the Exchange and DHCS for new enrollment into Medi-Cal***. Rather than relying on state and county enrollment officials to identify missing data necessary for enrollment, notify the beneficiary, and then wait for a response, it could greatly increase the efficiency and ease of data collection to use the same web-based portal and application assistance Navigators as will be used for Exchange and new Medi-Cal enrollment. The integration of the data collection and enrollment process for the transitioning LIHP populations into the statewide process would reduce backlogs and duplicative efforts on the part of DHCS, the counties, and the Exchange.

We appreciate DHCS' reaching out to stakeholders for feedback, and look forward to partnering on the LIHP transition into Medi-Cal. If there are any questions regarding the above recommendations or comments, please contact Andie Patterson, Deputy Director of Regulatory Affairs at apatterson@cpca.org or 916-440-8170.

Sincerely,

Andie Patterson, MPP
Deputy Director of Regulatory Affairs
California Primary Care Association